**U.S. Department of Labor**

Office of Administrative Law Judges
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**Issue Date: 14 July 2006**

CASE NO. 2005-BLA-5231

In the Matter of

EDWARD J. MORRIS, Deceased,
Claimant,

v.

BETH ENERGY MINES, INC.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Cheryl Cowen, Esquire
For the Claimant

John J. Bagnato, Esquire
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

## DECISION AND ORDER – AWARDING BENEFITS

This proceeding arises from a claimant's subsequent claim after a denial of his prior claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* (the Act). (DX 1).[1] The Act and implementing regulations, 20 C.F.R. Parts 410, 718, and 727 (Regulations), provide compensation and other benefits to coal miners who are totally disabled by pneumoconiosis and to the surviving dependents of coal miners whose death was due to pneumoconiosis.

[1] In this Decision, "DX" refers to Director's exhibits; "CX" refers to Claimant's exhibits; "EX" refers to Employer's exhibits; and "TR" refers to the transcript of the hearing held on November 2, 2005.

The Act and Regulations define pneumoconiosis (commonly known as black lung disease, coal workers' pneumoconiosis, or CWP) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. 20 C.F.R. § 725.101.

## PROCEDURAL HISTORY

The Claimant, Edward J. Morris filed an application for benefits on January 30, 1989. (DX 1). It was denied on July 26, 1989, on the basis that Claimant had failed to establish the existence of pneumoconiosis, that the disease was caused at least in part by coal mine work or that he was totally disabled by the disease. Claimant filed another application on June 5, 1990, which was treated as a request for modification. (DX 1). Claimant was advised by the Department of Labor that he needed to show a change in conditions or that a mistake in a determination of fact had been made in the prior denial. Another application was filed on September 1, 1992. (DX 2). It was denied on December 8, 1992.

On June 6, 1994, Claimant filed another application for benefits. (DX 3). He subsequently sought to have his claim withdrawn and a Notice of Withdrawal was issued on February 24, 1995, pursuant to 20 C.F.R. § 725.306. Claimant filed the instant application on May 12, 2003. (DX 5). The District Director issued a Proposed Decision and Order on August 12, 2004, in which he denied benefits and on August 17, 2004, Claimant filed a request for a hearing. (DX 54, 55). This matter was then referred to the Office of Administrative Law Judges for a formal hearing. (DX 59).

On November 2, 2005, I held a hearing in Pittsburgh, Pennsylvania. The Claimant and Employer, both represented by counsel, were afforded full opportunity to present evidence and argument. I admitted Director's exhibits 1–62, Claimant's exhibits 1–4, and Employer's exhibits 1-4. (TR 5–7). The parties were also provided time, post-hearing, to submit additional evidence, as well as post-hearing briefs. (TR 15). By cover letter dated January 25, 2006, Employer has submitted the deposition testimony of Dr. Renn as Employer's exhibit 5, an x-ray reading by Dr. Wolfe as Employer's exhibit 6, the deposition testimony of Dr. Bush as Employer's exhibit 7, and the deposition testimony of Dr. Fino as Employer's exhibit 8. Claimant has submitted the deposition testimony of Dr. Cohen as Claimant's exhibit 6.[2] Employer's exhibits 5-8 and Claimant's exhibit 6 are hereby admitted into evidence. Both parties have submitted written argument, post-hearing. The record is now closed.

At the hearing, the parties stipulated that Claimant was a coal miner with forty-two years of qualifying coal mine employment, that his widow, Margaret, was a proper augmentee, and that Employer was properly designated as the Responsible Operator. (TR 9). Additionally, in a post-hearing brief, Employer has conceded the existence of pneumoconiosis arising out of coal mine employment and that a material change in conditions has been established. The issues set forth below remain to be adjudicated.

[2] It should be noted that there does not appear to be a Claimant's exhibit 5. The designation of the exhibit number is that made by counsel for Claimant in her cover letter for the exhibit.

## ISSUES

(1) Whether the miner was totally disabled; and,

(2) Whether the miner's total disability was due to pneumoconiosis.

(DX 59, TR 9-10).

## FINDINGS OF FACT

### Widow's Testimony

The Claimant died on February 12, 2005. (TR 11). His widow, who pursued this claim after his death, testified that her husband had difficulty breathing. (TR 11). Dr. Kasigha was the Claimant's treating physician. (TR 12). Claimant was a smoker, who quit smoking approximately twenty years prior to his death. (TR 12). Claimant was diagnosed with lung cancer and had a lung removed as well as radiation treatment in the early 1990's. His last coal mine job was that of a lamp man. (TR 14). It was above ground and entailed custodial and maintenance work.

### Dependency

The parties have stipulated that Margaret Morris was a dependent of the Claimant, and I so find. (TR 9; DX 5, 13). I find that Claimant had one dependent for purposes of benefit augmentation.

### Coal Mine Employment

The records establish coal mine employment from 1947 to 1988 with Beth Energy Mines, Inc. (DX 7, 9). As noted, the parties have stipulated to forty-two years of coal mine employment and that Beth Energy Mines, Inc. was properly designated the responsible operator herein.

### Subsequent Claim

The Claimant's last work as a coal miner was within the State of Pennsylvania, which is located within the jurisdiction of the Third Federal Circuit. The Benefits Review Board applies the law as it is interpreted by the applicable Circuit. *Shupe v. Director, OWCP*, 12 BLR 1-200 (1989).

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. *See* 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim, which is denied on the basis of the prior denial unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the

prior claim became final. 20 C.F.R. § 725.309(d). Under this regulatory provision, according to the Court of Appeals for the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993, 997–998 (6th Circuit 1994):

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

The Court of Appeals for the Third Circuit, which has jurisdiction over this claim, has followed the *Sharondale* approach. *Labelle Processing Company v. Swarrow*, 72 F.3d 308 (3rd Cir. 1996). I interpret the *Sharondale* approach to mean that the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. In the denial of the miner's prior claim, it was found that he had failed to establish the existence of pneumoconiosis arising out of coal mine employment or total disability due to pneumoconiosis. In this case, Employer has conceded the existence of coal workers' pneumoconiosis, an element not previously established. Therefore, Claimant has established a change warranting a review of the entire record.

I have reviewed the evidence submitted in the prior claims and find that it cannot assist Claimant in this matter. Those records, dating from 1989, 1992, and 1994, include negative x-ray readings, non-qualifying pulmonary and blood gas study results, and three opinions rendered by Dr. Yong Dae Cho. In 1989, Dr. Cho found no significant pulmonary disease. (DX 1). In 1992 and 1994, Dr. Cho makes no mention of coal workers' pneumoconiosis, diagnosing lung cancer. (DX 2, 3). The newly submitted evidence is detailed below.

Medical Evidence

Chest X-rays

| Exh. # | X-ray Date | Physician/Qualifications[3] | Interpretation |
|---|---|---|---|
| DX 16 | 6/18/03 | Thomeier, B BCR | q/q, 1/0 |
| DX 23 | 6/18/03 | Thomeier, B BCR | q/q, 1/0 |
| DX 25 | 6/18/03 | Navani, B BCR | U/R |
| DX 50 | 6/18/03 | Fino, B | No pneumo |
| DX 56 | 9/9/03 | Ahmed, B BCR | p/q, 1/1 |
| DX 49 | 9/9/03 | Wolfe, B BCR | No pneumo |
| DX 22, 26 | 12/1/03 | Thomeier, B BCR | q/q, 1/0 |
| DX 24 | 12/1/03 | Navani, B BCR | Quality 2 |
| CX 2 | 12/1/03 | Ahmed, B BCR | p/q, 1/1 |
| DX 42 | 12/1/03 | Cappiello, B BCR | p/q, 1/1 |
| EX 2 | 2/19/04 | Renn, B | No pneumo |
| DX 50 | 2/19/04 | Fino, B | No pneumo |
| CX 1 | 5/4/05 | Cohen, B | q/t, 1/1 |
| EX 6 | 5/4/04 | Wolfe, B BCR | No pneumo |
| EX 2 | 9/14/04 | Renn, B | No pneumo |

[3] The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. § 37.51 (1982).

The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii).

Pulmonary Function Studies

| Exh. #/ Physician | Date | Age/Height[4] | FEV1 | MVV | FVC | Impression |
|---|---|---|---|---|---|---|
| DX 47 Kottner | 6/28/00 | 73/69.0" | 1.50 | 64 | 2.19 | Severe restriction without obstruction. No effect on bronchodilator. |
| DX 19 Celko | 6/17/03 | 76/67.5" | 1.39<br>1.45* | | 2.07<br>2.03* | Severe obstructive ventilatory pattern, no significant bronchodilator response. |
| DX 50 Fino | 2/19/04 | 77/68" | 1.27<br>1.31* | | 1.93<br>1.88* | |
| CX 1 Cohen | 5/4/04 | 77/67" | 1.7<br>1.72* | 65 | 2.39<br>2.36* | Moderate restrictive defect with diffusion impairment and hypoxemia. |
| EX 1 Renn | 9/14/04 | 77/68" | 1.42<br>1.45* | 51<br>58* | 2.21<br>2.10* | Moderate restrictive ventilatory defect. Diffusing capacity moderately reduced but corrects to normal when considering alveolar volume. |

*post-bronchodilator

Drs. Kucera and Fino found the June 17, 2003 study to be acceptable. (DX 20; EX 1). Dr. Kucera is board-certified in internal medicine, pulmonary disease, and critical care medicine. Dr. Fino is board-certified in internal medicine and pulmonary disease.

Additionally, it should be noted that the regulations only provide table values for miners up to seventy-one years of age. These studies were conducted after the Claimant had attained the age of seventy-one years. The regulations do not prohibit an administrative law judge from finding, by extrapolation, appropriate table values for miners older than seventy-one years of age. *See Horne v. Director, OWCP*, BRB No. 02-0466 BLA (March 24, 2003)(unpublised). If extrapolation were utilized, the studies which, as discussed below were found to be qualifying, continue to be qualifying.

[4] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983). As there is a variance in the recorded height of the miner from 67" to 69", I find that Claimant was 67.7" in height, in determining whether the studies qualify to show disability under the regulations.

Arterial Blood Gas Studies

| Exh. # Physician | Date | pCO2 | PO2 | Qualify? | Impression |
|---|---|---|---|---|---|
| DX 18 Celko | 6/17/03 | 36 | 83 | No | |
| DX 50 Fino | 2/19/04 | 37 | 64 | No | |
| CX 1 Cohen | 5/4/04 | 36 | 67.5 | No | |
| EX 2 Renn | 9/14/04 | 40 | 68 | No | Normal for age |

*post-exercise

Physicians' Reports

Dr. David Celko examined Claimant on August 4, 2003. (DX 17). He considered a coal mine employment history from 1946 to 1988 and a smoking history of "1" with the Claimant having started smoking at the age of ten years and having stopped at the age of fifty-six years. [5] Dr. Celko noted Claimant's chief complaints as sputum, wheezing, dyspnea, cough, and ankle edema. Dr. Celko conducted an x-ray, a pulmonary function study, a blood gas study, and an EKG. He found a severe obstructive defect on pulmonary function testing and normal resting blood gas studies. Based upon his examination, he diagnosed (1) pneumoconiosis, q/q, 1/0; (2) bronchogenic carcinoma; (3) coronary artery disease; and (4) COPD, bronchitis. He found the first condition to be due to occupational dust exposure, the second to cigarettes, and the fourth to cigarettes and dust exposure. In his opinion, Claimant was totally disabled from his last job as a lamp man or equivalent employment and all of the diagnosed conditions contributed to the disability. Dr. Celko stated that he could not sort out the pulmonary changes for dust exposure versus tobacco smoking.

Medical records from Washington Hospital have been submitted. (DX 47). In 1998, Claimant was hospitalized suffering from congestive heart failure, coronary artery disease, and angina pectoris. He underwent coronary artery bypass grafting in 1998. It was noted that Claimant had had cancer of the lungs in 1992, status post chemotherapy and radiation therapy. The Impression listed by Dr. Hart in a Consultation Record included coronary artherosclerotic heart disease, carcinoma of the lung, hypertension, nicotine abuse, and arteriosclerotic peripheral vascular disease.

Claimant underwent angioplasty in 1999. His chief complaint was leg pain. Dr. Finn recorded severe peripheral vascular disease with threatened extremity and thyroidal carotid bruits. Claimant underwent an angiogram. The Claimant was seen in June of 2000. The plan was to admit Claimant for angioplasty of the right SFA, followed by aorta bifemoral bypass. Dr.Finn listed an Impression of severe peripheral vascular disease with severe disease of both iliac arteries and disease of the SFA bilaterally. Claimant was hospitalized on July 13, 2000 and

[5] It is assumed that Dr. Celko intended to indicate one pack of cigarettes per day.

discharged on July 20, 2000. Dr. Finn recorded that Claimant had a history of severe vascular disease. The Diagnosis on Admission was (1) threatened extremity secondary to ilio-femoral disease; (2) history of severe cardiomyopathy secondary to ischemia; (3) history of coronary artery bypass graft, 1998; (4) ejection fraction in the 25% range; (5) aortic stenosis, mild: (6) history of non-small cell lung cancer, treated by chemotherapy and radiation in 1992; (7) history of hypertension; (8) history of hypothyroidism; (9) chronic pulmonary disease; and (10) arthritis. Dr. Finn recorded that the Claimant underwent an aorto-bifemoral bypass graft with concomitant aortic endarterectomy and right common femoral endarterectomy. In a Consultation Report, Dr. Corwin listed an Impression which included chronic lung disease, perhaps more so restrictive, as the eighth diagnosis listed. It was noted that Claimant was a former smoker who quit some twenty years ago. Dr. Corwin noted that the pulmonary function testing which had recently been done showed severe restriction without obstruction. Bronchodilators were ineffective and effusion was severely reduced. Dr. Corwin added, "[p]erhaps he has some type of scarring or fibrotic lung disease after the chemotherapy and radiation." Dr. Bowman also performed a consultation during this hospitalization. He listed a pack a day of cigarette smoking since childhood years, noting that the Claimant had quit smoking twenty years ago. Dr. Bowman's Impression included status post aorto-fem bypass, history of lung carcinoma, former heavy smoker, history of coronary artery bypass grafting, cardiomyopathy, and hypothyroidism.

A biopsy of the lymph nodes taken on July 14, 2000 showed chronic lymphadenitis, atherosclerotic plaque, and calcified atherosclerotic plaque. Dr. Pataki was the pathologist. Chest x-rays taken during this hospitalization were not read for the purpose of diagnosing or classifying pneumoconiosis. X-rays taken on July 17, 2000 and July 18, 2000 were read by Dr. Edgar as showing scattered densities throughout the lungs, too small to characterize, but could be scattered areas of fibrotic change and/or atelectasis.

A CT scan taken on August 15, 2001 was read by Dr. Kottner. He found scattered fibrotic changes. In 2002, Claimant underwent a bilateral femoral angiogram. He had been hospitalized with a chief complaint of painful, inflamed right foot. The discharge summary by Dr. Kottner listed (1) cellulites, right foot; (2) gout; (3) peripheral vascular disease; (4) coronary atherosclerotic heart disease, stable; and (5) lung cancer, stable. In April of 2002, Claimant was hospitalized with a chief complaint of severe bradycardia, junctional rhythm, and digitalis toxicity.

Medical records from Dr. Wayne Pfrimmer have been submitted. (DX 48). Those records date from 1992 to 2003 and deal with Claimant's treatment for lung carcinoma. CT scans and chest x-rays taken during this time period were not read for diagnosing pneumoconiosis. Records dated May 23, 2002 through December 18, 2003 from Dr. Alexis Megaludis are included. His initial Impression included normochromic, normocytic anemia and the records deal with Claimant's treatment for his chronic anemia.

On February 19, 2004, Claimant was examined by Dr. Gregory Fino, who is board-certified in internal medicine and pulmonary disease. (DX 50). Dr. Fino recorded that Claimant had smoked between half a pack and one and a half packs of cigarettes every two days for forty-seven years, from 1937 until 1984. A work history of forty-three years in the coal mines was

also recorded, that employment having ended in 1987 and with all but three years having been underground. Dr. Fino recorded that Claimant had had a breathing problem, characterized by shortness of breath, for the last twenty years, which was getting worse. Based upon his examination, which included the taking of a chest x-ray, a review of additional x-rays from 2003, pulmonary function testing, and blood gas studies as well as a review of the hospital records, Dr. Fino diagnosed severe cardiomyopathy, obstructive lung disease, restrictive lung disease, and history of lung cancer. He found that while the chest x-ray was very abnormal, it was not consistent with a coal mine dust related pulmonary condition. In his opinion, the x-ray evidence showed right-sided changes indicating marked volume loss of the right lung related to lung cancer and subsequent treatment with radiation therapy and chemotherapy.

Dr. Fino stated as follows regarding Claimant's obstructive lung disease:

> Smoking would be a risk factor in the etiology of this man's obstructive lung disease. The patient also worked 43 years in the mining industry, and that would be an etiology in the obstructive abnormality. Therefore, in my opinion, the obstructive component in this case is probably related to both smoking and coal mine dust exposure. However, it is not obstruction that is causing any significant respiratory impairment or disability. In fact, the obstruction is really fairly insignificant when compared to the restrictive defect.

Dr. Fino found that the restrictive defect was directly related to Claimant's history of lung cancer and treatment for lung cancer. While Claimant was totally disabled from a respiratory standpoint, the disability was related to his cancer and treatment for cancer. In his opinion, there was insufficient objective evidence to justify a diagnosis of simple coal workers' pneumoconiosis as defined either clinically or legally. He did find a disabling respiratory impairment and concluded that it was not caused or contributed to by the inhalation of coal mine dust.

The deposition testimony of Dr. Fino was taken on March 28, 2005. (EX 4). Dr. Fino testified that he found the obstructive component of Claimant's pulmonary impairment to probably be related to both cigarette smoking and coal mine dust exposure. The x-ray findings were not consistent with coal workers' pneumoconiosis. Chemotherapy and radiation therapy were the cause of the problems in Claimant's right lung. Claimant's obstruction from a pulmonary standpoint was of no clinical significance in this case and was not participating in any impairment or disability. This was evidenced by the fact that he had no obstruction in 1989 prior to the development of his lung cancer and that was two years after he left the mines, and there was no obstruction in 1992 or 1994 after he left the mines. If the only disability Claimant had were the obstruction due to coal mine dust exposure, Dr. Fino found he would be able to return to his last coal mine employment. Claimant's heart disease was a significant contributing factor of his shortness of breath along with his restrictive lung problem. At this point, Claimant could not perform his last coal mine work, that inability stemming from his lung surgery and the treatments of radiation and chemotherapy.

Upon cross-examination, Dr. Fino stated that he was diagnosing legal pneumoconiosis in this case. In this respect, Dr. Fino stated his belief that his written report contained a typographical error, as the "in" should not have been before the word "sufficient" in his

conclusion regarding whether Claimant had legal or clinical pneumoconiosis. Dr. Fino also stated that pneumoconiosis can cause a restrictive impairment, however, in his opinion, if there is no evidence of pneumoconiosis on chest x-ray, this would not be possible because there has to be significant fibrosis present to have a restriction due to any kind of lung disease. Dr. Fino subsequently stated that he did not believe Claimant ever had lung surgery. With regard to the loss in pulmonary function study over the last twelve years, Dr. Fino found it could be due in part to aging and in part to continued changes due to the chemotherapy. In this case, there was a lack of pulmonary fibrosis on x-ray and a lack of an impairment on oxygen transfer, which led him to the conclusion that Claimant's pneumoconiosis had not progressed.

The deposition of Dr. Fino was continued on January 12, 2005. (EX 8). Dr. Fino was given the opportunity to review additional evidence, including hospital records, the death certificate, a chest x-ray reading by Dr. Wolfe, and the deposition transcripts of Drs. Renn and Cohen. Dr. Fino testified that he now believed that legal as well as clinical pneumoconiosis was present in the Claimant. His opinion as to disability, as set forth above, did not change. The most significant abnormality in the Claimant was a restriction related to Claimant's lung cancer with chemotherapy and radiation. Five percent of the lung tissue occupied by pneumoconiosis, as found by Dr. Bush, would not be enough fibrosis to result in restriction. Dr. Fino stated that lung tissue examination is the most sensitive way to determine pneumoconiosis because you are at the microscopic level. The amount of pneumoconiosis found by Dr. Bush would not normally be found on a chest film. Dr. Fino pointed to medical literature to support his assertion that there is a close association between the amount of emphysema due to coal dust inhalation resulting in functional impairment and the amount of clinical pneumoconiosis that is diagnosable either by chest film or autopsy. Therefore, the quantification of five percent was helpful in distinguishing the causes of emphysema due to tobacco smoking versus coal mine dust. Five percent pneumoconiosis would not cause clinically significant emphysema.

Dr. Robert A.C. Cohen examined the Claimant on May 4, 2004 and submitted a report dated May 26, 2004. (CX 1). He recorded shortness of breath for fourteen years; a smoking history starting at the age of twelve years, Claimant having quit smoking twenty years ago for a total of thirty-five years at the rate of one pack per day; and a work history of coal mine employment from 1947 to 1987. Dr. Cohen noted that Claimant had a thirty-five pack year history of smoking and a forty-three year history of working as a coal miner. Thirty-five of his coal mining years were at the face of the mine, and more than half of his career was during a time period when modern dust control regulations were not in effect.

Dr. Cohen had the opportunity to review the report of Dr. Fino and his x-ray readings. Based upon his examination, which included the taking of histories, a chest x-ray, pulmonary function testing, and blood gas studies, and his review of evidence, Dr. Cohen opined that Claimant suffered from coal workers' pneumoconiosis and that his chronic respiratory condition was substantially related to his forty-three years of coal mine employment. By way of explanation, Dr. Cohen pointed to Claimant's work history which he found to be significant for coal dust exposure, while finding that Claimant's smoking history did not significantly contribute to his pulmonary impairment. Dr. Cohen found Claimant's symptoms began while he was still a miner and pre-dated the onset of his cardiac disease and that the pulmonary function testing demonstrated severe restrictive lung disease with severe diffusion impairment. Dr. Cohen

stated that this diffusion impairment can be the result of interstitial lung disease as seen in coal workers' pneumoconiosis and was, to a reasonable degree of medical certainty, caused by Claimant's exposure to coal dust and tobacco smoke. A component of this impairment was also due to loss of lung volume from his prior pulmonary and cardiac surgery and residual pleural disease.

Dr. Cohen found the blood gas studies to be indicative of significant hypoxemia for the Claimant's age and the chest x-ray to be positive for pneumoconiosis. All these factors led to his conclusion that Claimant suffered from the disease. Dr. Cohen also found that Claimant's restrictive pulmonary impairment was significantly contributed to by his coal mine dust exposure, as evidenced by the Claimant's occupational history, physical exam, clinical history, and results of physiology testing. Claimant's positive chest x-ray and altered gas exchange in surface on his diffusion studies corroborated this conclusion. Claimant's heart disease and prior lung cancer with radiation therapy and his pleural disease were also significant contributors. Because Claimant had only minimal obstructive impairment, Dr. Cohen did not feel that Claimant's history of tobacco smoke exposure was a significant contributory factor to his pulmonary impairment. In his opinion, Claimant was clearly disabled from performing his prior coal mine work. Dr. Cohen is board-certified in internal medicine, pulmonary medicine, and critical care medicine.

The deposition testimony of Dr. Cohen was taken on December 1, 2005. (CX 6). Dr. Cohen testified that subsequent to his examination of the Claimant, he had the opportunity to review additional evidence, including records from Dr. Cho, Dr. Celko, Dr. Renn, and Dr. Fino, as well as hospital records. Dr. Cohen stated that Claimant met the criteria for chronic bronchitis as well as the conditions he recorded in his written report. Dr. Cohen acknowledged the possibility that Claimant may have had a forty-six year history of tobacco smoke exposure when rendering his opinion in the deposition. Dr. Cohen testified that he had reviewed the autopsy protocol report and found that it was consistent with his interpretation of the chest x-ray in this case. The autopsy showed that Claimant had significant interstitial lung disease caused by his coal dust exposure. It remained his opinion that Claimant clearly had coal workers' pneumoconiosis, interstitial lung disease caused by his forty-three years of exposure to coal mine dust. This exposure resulted in a significant restrictive impairment. According to Dr. Cohen, Claimant's lung cancer would not cause interstitial lung disease. He stated that chemotherapy would not play a role in the restrictive impairment, although radiation can cause some fibrosis which could have contributed to his restrictive impairment. Dr. Cohen testified that Claimant also met the criteria for chronic bronchitis and in his opinion, this condition was related to his coal mine dust exposure and his smoking history. Claimant's pneumoconiosis was a factor in his pulmonary disability, as he had pathological and radiological evidence of the disease, physiological evidence of a restrictive impairment with diffusion impairment, and resting hypoxemia.

Dr. Cohen was asked about the fact that Dr. Renn found some contradictions in his report, inasmuch as Dr. Cohen indicated that a component of the diffusion impairment was a result of loss of lung volume from previous surgery as well as exposure to coal mine dust and tobacco smoke yet later indicated that tobacco smoking was not significantly contributory, at the same time that he indicated that smoking was contributing to the diffusing capacity impairment.

Dr. Cohen explained that it was his opinion that the smoking would not cause a restrictive impairment but it could contribute to Claimant's diffusion impairment in that it can cause emphysema. In his opinion, the autopsy supported his findings as it showed that Claimant did have a component of emphysema. It was his opinion that emphysema could be caused by both coal dust and tobacco smoke exposure.

Dr. Cohen stated his disagreement with Dr. Renn's conclusion that Claimant did not have pneumoconiosis based on the findings on diffusion capacity. It was Dr. Cohen's opinion that Claimant had a diffusion capacity that was only 45% of normal. Dr. Cohen stated his disagreement as well with Dr. Fino's opinion that a restrictive impairment caused by pneumoconiosis can only occur with significant fibrosis on x-ray, that being a category two or higher. Dr. Cohen countered that a chest x-ray is not a very good predictor of lung function; the pulmonary function study is the best way to measure lung function. In his opinion, the impairment here was restrictive. Emphysema was contributory in this case but did not result in an obstructive impairment. It did, however, contribute to the diffusion impairment. Other factors were the fibroanthracotic macules and micro nodules and the pulmonary fibrosis, the latter being the result of radiation and coal and silica dust exposure. Dr. Cohen explained that the pulmonary fibrosis seen in this case could be idiopathic or it could be from his coal mine dust exposure, however, he could not make a firm diagnosis without a more detailed description of the microscopic pathology. The fibroanthracotic macules and micro nodules, however, were clearly from coal mine dust exposure. There was also pulmonary fibrosis related to radiation therapy.

Dr. Joseph J. Renn examined the Claimant on September 14, 2004. (EX 2). Dr. Renn is board-certified in internal medicine and pulmonary disease. Dr. Renn recorded Claimant's work, social, and medical histories, listing a smoking history of a pack per day from 1945 until 1984. Dr. Renn also reviewed medical evidence of record, noting the variations in Claimant's smoking histories which ranged from thirty-five to forty-six pack years. Based upon his examination and a review of the records, Dr. Renn opined that Claimant suffered from (1) chronic bronchitis without airway obstruction; (2) status post non-small cell carcinoma of the lung owing to tobacco smoking; (3) status post chemotherapy for #2; (4) status post radiation therapy for #2; (5) mild restrictive ventilatory defect owing to #4 above and #7 and #10 under cardiovascular system; and (6) a pneumoconiosis does not exist. Under cardiovascular system, Dr. Renn continued his diagnosis, listing as #7, chronic congestive heart failure and as #10 status post double coronary artery bypass grafting. He also noted under metabolic/endocrine system, hypothyroidism, gout, and exogenous obesity. In his opinion, none of the diagnoses he listed were caused or contributed to by exposure to coal mine dust. He did find Claimant to be totally and permanently disabled from his prior coal mine work. Dr. Renn found that Dr. Cohen's report was contradictory regarding the contribution of tobacco smoke to the impairment of diffusion because he stated that a component of the diffusion impairment was a result of loss of lung volume due in part of coal mine dust and tobacco smoke, yet he later stated that the tobacco smoke exposure was not a significantly contributory factor. Dr. Renn found it apparent that Claimant had a loss of lung volume and a restrictive ventilatory defect. While Claimant's x-ray showed deviation of trachea to the right and marked paramediastinal and apical pleural thickening on the right consistent with loss of lung volume and a restrictive ventilatory defect, this was multifactorial in nature, but coal workers' pneumoconiosis did not present with that

radiographic picture. It was his opinion that it never develops into that type of radiographic picture. Another very significant contribution to the diffusing capacity abnormality was Claimant's chronic congestive heart failure which had become biventricular. In his opinion, Claimant had coronary artery disease, hypertension, and CHF, a combination which resulted in an average decrease of the FVC of 14% and of the FEV1 of 17% in men.

The deposition testimony of Dr. Renn was taken on December 1, 2005. (EX 5). Dr. Renn testified that Claimant's lung cancer was not resectable and that he had received both chemotherapy and radiation therapy. He subsequently developed fairly severe heart disease, which gradually increased in severity. This caused pulmonary hypertension resulting from the aortic stenosis of the left side of the heart and the backpressure on the right side of the heart. Claimant went on to develop intractable heart failure, which resulted in kidney failure to the extent that Claimant had an increase in the amount of fluid in his body, which further worsened his heart failure. He died in congestive heart failure. According to Dr. Renn, Claimant had normal lung function in 1989 and that changed after he started treatment for cancer of the lung. The reason for the change was the lung cancer. Claimant developed changes known as a restrictive ventilatory defect as a result of the radiation therapy and chemotherapy. Dr. Renn reiterated that he did not find coal workers' pneumoconiosis to be present. The fact that the autopsy appeared to indicate that it was present did not change any of his opinions other than that regarding the existence of the disease. Dr. Renn asserted that mild simple pneumoconiosis found at autopsy has not been shown to be clinically significant or to impact ventilatory function. It would not cause the restrictive ventilatory defect such as was found in the Claimant.

According to Dr. Renn, Claimant was disabled from a pulmonary standpoint when he examined him, however, that disability was not related to coal mine dust. If it had been, Claimant would not have had normal diffusion when it was corrected for the alveolar volume. Claimant's abnormal diffusion capacity was primarily the result of his congestive heart failure, but it was also contributed to by the fibrosis he had from his radiation therapy. Dr. Renn did not diagnose emphysema in the Claimant. He did find chronic bronchitis to be present. He also did not believe that rales or crackles can result from pneumoconiosis if there is no x-ray, biopsy, or CT scan evidence of the disease process. Dr. Renn was of the opinion that at least a category 2 on the chest x-ray needs to be seen to relate a restrictive impairment to pneumoconiosis and that for the most part, pneumoconiosis will not progress absent additional exposure unless complicated pneumoconiosis is present. However, if an individual has sufficient silica exposure, progression can occur.

The death certificate lists the date of death as February 12, 2005 and the cause of death as valvular heart disease due to congestive heart failure. (EX 3). It is certified by Dr. Robin Anderson.

By report dated February 13, 2005, Dr. Cyril H. Wecht, who is a forensic pathologist, submitted his finding upon autopsy. (CX 4). The autopsy was performed on February 13, 2005. The Final Pathological Diagnosis included hypertensive and arteriosclerotic cardiovascular disease as well as chronic obstructive pulmonary disease. Under the latter, Dr. Wecht listed anthracosilicosis, pulmonary emphysema, pulmonary fibrosis, fibrohyaline and fibroanthracotic macules and micronodules, fibrohyalinization and fibroanthracosis of mediastinal and

peribronchial lymph nodes, cor pulmonale, pulmonary osteoarthropathy, and increased anteroposterior diameter of chest.

Dr. Stephen T. Bush reviewed medical evidence by report dated November 4, 2005, including thirty-six histologic slides. (EX 7). He found that Dr. Cohen's diagnosis of hypoxemia was erroneous, as shown by Dr. Renn, as the oxygen diffusion gradient calculated from Dr. Cohen's own data was, in fact, normal. Based upon his review, Dr. Bush found that Claimant had a mild degree of simple coal workers' pneumoconiosis, based on the presence of coal worker micronodules consisting of black dust pigment consistent with coal dust free in the tissue and in macrophages associated with a fibrous reaction forming rare micronodules up to 0.4 cm. Dr. Bush then went on to discuss the cause of death and the fact that cor pulmonale was not present. He did not address total disability.

The deposition testimony of Dr. Bush was taken on January 9, 2006. (EX 7). Dr. Bush is board-certified in anatomic and clinical pathology. Dr. Bush stated that he had the opportunity to review additional records, including the depositions of Drs. Renn and Cohen. Dr. Bush testified that upon review of the autopsy evidence including slides, he saw evidence of chronic congestive heart failure with pulmonary macrophages in the lungs as well as evidence of centrilobular emphysema. In his opinion, the latter was attributable to cigarette smoking. He also found mild coal workers' pneumoconiosis and chronic bronchitis to be present pathologically. Dr. Bush disagreed with Dr. Cohen's finding of pigmented fibrosis, noting that neither he nor Dr. Wecht found this to be present. Dr. Bush further remarked that Dr. Wecht's findings on microscopic description were very familiar to him because it was language used by Dr. Wecht in all of his reports. Copies of other reports from Dr. Wecht are attached as an exhibit to the deposition.[6] Dr. Bush also disagreed with Dr. Wecht's finding of cor pulmonale, basing this conclusion on the fact that Claimant had severe cardiac disease involving the left ventricle, coronary artery disease, hypertension, and cardiomyopathy producing congestive heart failure.

According to Dr. Bush, the findings pathologically indicated that the pneumoconiosis which was present was mild, involving no more than five percent of the lung tissue. Therefore, according to Dr. Bush, it was not a significant disease process in the Claimant. It was his opinion that clinically, without any other disease process, an individual with this degree of pneumoconiosis would not have any symptoms. Claimant's clinical course would have been the same had he never been exposed to coal mine dust.

Upon cross-examination, Dr. Bush indicated he was retired from performing autopsies and it had not been part of his practice to perform disability examinations on living miners. According to Dr. Bush, he would expect to see a significant amount of disease in the lungs confirmed microscopically as coal dust disease, and affecting about twenty percent of the lung tissue, abnormal x-ray findings, and an autopsy report describing lungs significantly involved by coal workers' disease changes, to determine that pneumoconiosis was a disabling disease process in a living miner. He would also expect to see pulmonary function testing showing disabling abnormalities and clinical symptoms of a chronic nature that were reflected in medical records by treating physicians.

[6] Claimant's counsel noted her objection to the inclusion of these redacted reports. That objection is overruled.

According to Dr. Bush, Claimant's clinical symptoms were not consistent with pneumoconiosis because his symptoms were not accompanied by the abnormalities he mentioned above. Also, his symptoms were not chronic, consistent, or severe enough to warrant treatment by his treating physicians. Cardiac disease, general debility, aging, and weakness can also cause the symptoms. Dr. Bush testified that pneumoconiosis can result in hypoxemia if the disease is severe and widespread. In this case, Dr. Bush found centrilobular emphysema to be present and significant to the point where it was moderate in degree. He did not, however, have an opinion as to whether it was causing symptoms in this miner. Dr. Bush found no evidence that Claimant had a pulmonary disability during his lifetime. He found no evidence of diffuse deposits of black anthracotic pigment on review of the autopsy slides. Dr. Bush stated that he found very few silica. He did find basically everything listed by Dr. Wecht as being present, however, it was his opinion that Dr. Wecht failed to indicate the severity of the disease, the size of the lesions, or the percent of the lungs involved. Dr. Wecht's description failed to indicate what the lungs really showed. In his opinion, the autopsy report was inconsistent and incomplete. Dr. Bush also disagreed with the cause of death listed by Dr. Wecht.

## CONCLUSIONS OF LAW

### Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, a claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202–718.205; *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). Evidence which is in equipoise is insufficient to sustain the Claimant's burden of proof. *Director, OWCP v. Greenwich Collieries, et al.*, 512 U.S. 267 (1994); *aff'g sub nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730 (3d Cir. 1993).

#### Pneumoconiosis

The regulations define pneumoconiosis broadly, as "a chronic disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment." 20 C.F.R. § 718.201. The definition includes not only medical, or "clinical," pneumoconiosis but also statutory, or "legal," pneumoconiosis. *Id.* Clinical pneumoconiosis comprises:

> Those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silico-tuberculosis, arising out of coal mine employment.

*Id.* Legal pneumoconiosis, on the other hand, includes "any chronic lung disease or impairment and its sequelae" if that disease or impairment arises from coal mine employment. *Id.* A claimant's condition "arises out of coal mine employment" if it is a "chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." *Id.* Finally, the Regulations reiterate that pneumoconiosis is "a latent and progressive disease" that might only become detectable after a miner's exposure to coal dust ceases. *Id.*

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151–152 (1987). However, this rule is not mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319–320.

The regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that Claimant has pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(1)–(4). In the instant case, as noted, Employer has conceded the issue of pneumoconiosis. This concession is supported by the preponderance of positive readings, as well as by the autopsy evidence and the medical reports. Accordingly, I find that pneumoconiosis has been established pursuant to 20 C.F.R. § 718.202(a).

Cause of Pneumoconiosis

If pneumoconiosis has been established, it must also be established that the miner's pneumoconiosis arose, at least in part, out of his coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, then there is a rebuttable presumption that the pneumoconiosis arose out of such employment. In this case, Employer has conceded that Claimant's pneumoconiosis arose out of his coal mine employment. I find that Claimant, with forty-two years of coal mine employment, is clearly entitled to the rebuttable presumption at § 718.203. As the evidence is not sufficient to rebut the presumption and Employer has conceded as much, I find that Claimant has established pneumoconiosis arising out of coal mine employment.

Total Disability

The Claimant must show that his total pulmonary disability was caused by pneumoconiosis. 20 C.F.R. § 718.204(b). Sections 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (iv) reasoned medical opinions concluding that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony. Under this subsection, the ALJ must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, then the ALJ must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory

disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on recon. en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable to this claim because there is no evidence that the Claimant suffers from cor pulmonale with right-sided congestive heart failure. While Dr. Wecht, in his autopsy report, lists cor pulmonale, he does not list right-sided congestive heart failure, as required by 20 C.F.R. § 718.204(b)(2)(iii). Section 718.204(d) is not applicable because it only applies to a survivor's claim or a deceased miner's claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. A claimant may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies showing an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the bloodstream. 20 C.F.R. § 718.204(b)(2)(ii). More weight may be accorded to the results of a recent blood gas study over one conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

In the instant matter, all of the pulmonary function studies, except for the May 4, 2004 study conducted by Dr. Cohen, produced values indicative of total disability. Based upon the preponderance of qualifying studies, I find that total disability has been established pursuant to § 718.204(b)(2)(i).

Of the four newly submitted blood gas studies, none produced qualifying values. I find that the blood gas study evidence fails to establish total disability by a preponderance of the evidence, pursuant to § 718.204(b)(2)(ii).

Total disability may also be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b). Under this subsection, I must examine all the evidence of record "relevant to the question of total disability due to pneumoconiosis . . . with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201, 1-204 (1986). I must compare the exertional requirements of the Claimant's usual coal mine employment with a physician's assessment of the Claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once the miner has demonstrated that he is unable to perform his usual coal mine work, he has made a prima facie case of total disability; the burden of going forward with evidence to prove that the Claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined at § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

Dr. Celko found Claimant to be totally disabled from his last coal mine work due to his pulmonary impairment, an opinion shared by Dr. Cohen as well as Drs. Fino and Renn.

Dr. Wecht, a pathologist, made no findings regarding total disability and Dr. Bush, who is a pathologist, opined that he found no evidence that Claimant had a pulmonary disability during his lifetime. I find the opinions of Drs. Celko, Cohen, Fino, and Renn, all of whom concluded that Claimant was totally disabled as a result of a pulmonary impairment, outweigh the opinion of Dr. Bush, who is a pathologist and not a pulmonologist. Claimant's treatment records also support this finding inasmuch as they mention chronic pulmonary disease. Accordingly, I find the medical opinion evidence sufficient to establish total disability pursuant to 20 C.F.R. § 718.204(b)(iv).

After consideration of all the evidence under § 718.204(b)(2), like and unlike, I find the medical opinion evidence and the preponderance of the recent pulmonary function studies, to be the most probative. I rely on the medical opinions because they are the culmination of a physical examination of the Claimant, an understanding of the exertional requirements of his coal mine employment, and years of experience in the field of pulmonary medicine. Those reports are well supported by the pulmonary function testing. Accordingly, I find that Claimant has established, by a preponderance of the evidence, that he is totally disabled.

Total Disability Causation

Claimant must establish by a preponderance of the evidence that his total disability is due to pneumoconiosis. *Baumgartner v. Director, OWCP*, 9 BLR 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 BLR 1-4, 1-6 (1986) (*en banc*). The amended regulations require that the pneumoconiosis be a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Section 718.204(c)(1) sets forth that pneumoconiosis is a substantially contributing cause of disability if it either (1) has a material adverse effect on the miner's respiratory condition or (2) materially worsens a totally disabling respiratory impairment caused by a disease unrelated to coal mine employment.

Thus, while total disability has been established, in order to be entitled to benefits, Claimant must establish that that disability was due to his coal workers' pneumoconiosis. The reports of Dr. Cho, dating from 1989 to 1994, fail to find a totally disabling respiratory impairment due to coal mine dust exposure. In 2004, Dr. Fino found an obstructive abnormality due to cigarette smoking and coal mine dust exposure, finding, however, no impairment resulting therefrom. What he found to be disabling was Claimant's restrictive impairment secondary to cancer and its treatment. Dr. Renn also found a pulmonary disability resulting from Claimant's cancer and its treatment. After performing an autopsy, Dr. Wecht makes no assessment regarding disability or its causation. Dr. Bush found a mild degree of simple coal workers' pneumoconiosis to be present on autopsy and concluded that Claimant's emphysema, which he categorized as moderate, was attributable to smoking. He found Claimant's pneumoconiosis to be mild and therefore, not a significant disease process in the Claimant. Claimant's symptoms were not consistent with pneumoconiosis, in his opinion. While Dr. Bush did not have an opinion as to the symptoms that emphysema may have caused in the miner, he did opine that he found no evidence that Claimant had a pulmonary disability during his lifetime.

By contrast, Dr. Celko finds a severe obstructive defect and finds total disability due to all of Claimant's diagnosed conditions, including pneumoconiosis and "COPD, bronchitis," a

condition, which he concludes is due to tobacco smoke and coal mine dust exposure. This finding regarding the etiology is similar to that found by Dr. Fino, although Dr. Fino finds no impairment resulting from the obstructive pulmonary abnormality. Dr. Cohen finds total disability due to Claimant's pneumoconiosis, further finding that Claimant's restrictive impairment was significantly contributed to by his coal mine dust exposure, as well as by his heart disease and prior lung cancer with radiation therapy and his pleural disease.

The treatment records, while detailing Claimant's medical problems which include heart disease, nicotine abuse, and chronic pulmonary disease, do not render a reasoned medical opinion on this issue, and therefore, cannot assist Claimant. That they do mention chronic lung disease, however, is of significance. In one such record, Dr. Corwin notes that bronchodilators were not effective and remarks that there may be some type of scarring or fibrotic lung disease after chemotherapy and radiation, thus supporting the findings rendered by those physicians who find Claimant's lung abnormalities to his cancer treatment.

Upon reviewing these medical opinions, I find that Claimant's cancer and its treatment did, indeed, result in pulmonary impairment. I further find, however, that this does not negate the possibility that a significant role was played as well by his forty-two years of coal mine dust exposure. The autopsy findings were positive for clinical pneumoconiosis. Claimant also suffered from chronic bronchitis, chronic obstructive pulmonary disease, and emphysema, which well reasoned medical opinions have attributed to his coal mine dust exposure.

Dr. Fino's opinions have ranged from no clinical or legal pneumoconiosis, to a finding that both existed in the Claimant, leaving his conclusions on this issue less than persuasive. Dr. Renn finds Claimant's clinical pneumoconiosis could not have caused his restrictive lung impairment. This, however, does not negate the possibility that it worsened Claimant's pulmonary condition. I do not find the opinions of Drs. Bush, Renn, or Fino sufficient to outweigh the contrary findings rendered by Drs. Celko and Cohen, namely that Claimant's coal mine dust exposure has in fact contributed to Claimant's total pulmonary disability when the clinical findings and reasoning behind the opinions are fully weighed and reviewed along with the autopsy evidence.

I find, based upon the medical opinions of Drs. Celko and Cohen, that legal pneumoconiosis has been a significant contributor to Claimant's total disability. Thus, as noted, Drs. Renn and Fino eventually concede the existence of pneumoconiosis, as well as significant pulmonary conditions. Dr. Fino states that pneumoconiosis can cause a restrictive impairment, while finding all of Claimant's restrictive impairment to be due to his cancer and treatment for that disease. Dr. Renn finds that the mild simple pneumoconiosis found at autopsy was not clinically significant, failing to find emphysema to be present and further opining that the restrictive impairment found in the Claimant was not caused by his pneumoconiosis. It would appear that Drs. Renn and Fino focus primarily on clinical pneumoconiosis, relying on the autopsy findings regarding fibrosis to render their opinions as to the effect that Claimant's pneumoconiosis may have had on his pulmonary condition. Indeed, before the autopsy was performed, Dr. Renn found no evidence of pneumoconiosis, while Dr. Fino found a pulmonary abnormality due to coal mine dust and tobacco smoke exposure, insignificant however, to render a diagnosis of pneumoconiosis. It does not appear that the issue of legal pneumoconiosis was

fully considered. I do not find their opinions sufficient to negate the finding, as rendered by Drs. Celko and Cohen, that coal mine dust exposure was a significant contributor to Claimant's pulmonary disability.

Drs. Celko and Cohen diagnosed clinical and legal pneumoconiosis and found Claimant totally disabled by the disease. Their findings were subsequently supported by the autopsy. I find their conclusions regarding Claimant's pulmonary disability to be the better-reasoned and better-supported. The fact that Claimant's lung cancer may have rendered him totally disabled even without exposure to coal mine dust does not preclude the possibility that Claimant's pulmonary condition was materially worsened by his pneumoconiosis. Based upon the medical opinions of Drs. Cohen and Celko, I find that Claimant's pulmonary disability was due to pneumoconiosis pursuant to 20 C.F.R. § 718.204(c).

## Conclusion

As Claimant has established pneumoconiosis due to coal mine employment and total disability due thereto, I conclude that he has established entitlement to benefits under the Act.

## Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed. 20 C.F.R. § 725.503. As I find that the evidence does not establish the month of onset, I find Claimant entitled to benefits as of May 1, 2003, the month in which he filed this subsequent claim for benefits.

## Attorney's Fees

No award of attorney's fees for services to the Claimant is made herein because no application has been received from counsel. A period of 30 days is hereby allowed for the Claimant's counsel to submit an application. *Bankes v. Director*, 8 B.L.R. 2-l (l985). The application must conform to 20 C.F.R. §§ 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties, including the Claimant and Solicitor as counsel for the Director. Parties so served shall have 10 days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge the Claimant any fee in the absence of the approval of such application.

ORDER

The claim for benefits filed by Edward J. Morris is hereby GRANTED.

A

MICHAEL P. LESNIAK
Administrative Law Judge

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).